Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR WALTER DEL GALLO MD PA
14317 NORTHWEST BLVD SUITE A
CORPUS CHRISTI TEXAS 78410

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-0795-01

MFDR Date Received
October 31, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement with the DWC060 request.

Amount in Dispute: $475.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual is in receipt of a medical dispute filed by you that was received at the TDI/DWC on 10/31/2011. Please not that the date(s) of service in dispute are 05/19/10 to 5/26/10 therefore, these dates are not eligible for Medical Dispute Resolution in accordance with Rule 133.307 (C)(1)(A), a copy of rule is enclosed... The billed charges were initially denied as not pre-authorized. [Injured worker] had a surgical procedure done on 05/04/10. In accordance with Rule 134.600 (P) (C-ii) six (6) visits of physical/occupational therapy following a surgical intervention previously authorized by the carrier is allowed. However, the dates in dispute feel outside the allowed 2 week period and were denied accordingly. The disputed date(s) are also prior to the dates lilsted [sic] on the authorization letter dated 06/25/10 submitted by the provider."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19, 2010, May 21, 2010 and May 26, 2010	97010-GP, 97140-GP, 97032-GP and 97110-GP	$475.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 9, 2010 and October 4, 2011
   - X815 – This procedure is incidental to the primary procedure, and does not warrant separate reimbursement
   - X170 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600

Issues

1. What is the filing deadline for requesting Medical Fee Dispute Resolution?
2. Did the requestor file the request for Medical Fee Dispute Resolution timely and according to the provisions of 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.307 (c)(1)(A) states in pertinent part, "A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability; (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or(iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice..."
   - The requestor disputes dates of service May 19, 2010, May 21, 2010 and May 26, 2010.
   - The Medical Fee Dispute Resolution received the DWC060 request on October 31, 2011.
   - The requestor did not submit documentation indicating that they met the exceptions to the one year filing deadline. As a result, the dispute was submitted untimely to MFDR and is therefore not eligible for review.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.